

**BEFORE THE APPEALS BOARD
FOR THE
KANSAS DIVISION OF WORKERS COMPENSATION**

JOHN G. EISELE)	
Claimant)	
)	
VS.)	
)	Docket No. 210,310
LITTLE CAESARS KANSAS CITY)	
Respondent)	
AND)	
)	
ST. PAUL FIRE & MARINE INSURANCE CO.)	
Insurance Carrier)	

ORDER

Respondent appealed Administrative Law Judge Robert H. Foerschler's November 9, 1999, Preliminary Decision.

APPEARANCES

The claimant, John G. Eisele of Kansas City, Missouri, appeared pro se. The respondent and its insurance carrier appeared by their attorney, Kristine A. Purvis of Overland Park, Kansas.

RECORD

The Appeals Board has considered the record listed in the December 11, 1997, Award and the October 21, 1999, preliminary hearing transcript including the exhibits.

STIPULATIONS

The Appeals Board has adopted the stipulations listed in the December 11, 1997, Award.

ISSUES

This is a post-award medical request filed by the claimant for payment of necessary medical expenses allegedly incurred for treatment related to a September 12, 1993, work-related low-back injury. The Administrative Law Judge granted claimant's request and ordered the respondent to pay the expenses as authorized medical expenses. Additionally, the Administrative Law Judge referred the medical bills to the Division Medical Director for review under K.S.A. 1999 Supp. 44-510.

On appeal, respondent contends claimant's request for payment of the medical expenses should be denied. Respondent argues claimant failed to prove the medical expenses were for treatment causally related to claimant's September 12, 1993, low-back injury. Further, respondent contends the Administrative Law Judge erred in referring the medical bills for review to the Division Medical Director. Respondent raised this issue in its application for review but does not make any arguments in its brief concerning this issue.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

After reviewing the record and considering the arguments contained in the parties' briefs, the Appeals Board, for reasons stated below, concludes the Administrative Law Judge's decision ordering respondent to pay the medical expenses submitted by the claimant for treatment of his low-back condition should be affirmed.

FINDINGS OF FACT

1. On December 11, 1997, the Administrative Law Judge awarded claimant a 42 percent permanent general disability based on the parties' stipulation that claimant had sustained a 42 percent permanent functional impairment as a result of a September 12, 1993, work-related low-back injury. Future medical treatment was awarded upon proper application and approval of the Director.

2. Medical treatment for claimant's September 12, 1993, work-related low-back injury was voluntarily provided by respondent with orthopedic surgeon Robert P. Bruce, M.D. On September 27, 1993, as a result of claimant's low-back injury, Dr. Bruce performed a right L5-S1 laminotomy with disk excision, nerve root decompression, and free fragment excision.

3. Post-surgery, claimant developed a deep venous thrombosis and was again hospitalized. Likewise, claimant was hospitalized on October 18, 1993, because of increasing back and right leg pain.

4. On October 20, 1993, Dr. Bruce operated on claimant's low back for the second time in an effort to relief claimant's increasing pain and discomfort. But this time, the doctor performed a disectomy at the L4-L5 level and removed another, but smaller, free disk fragment at L5-S1.

5. After the October 20, 1993, surgery, claimant developed severe complications from the surgeries that included diskitis, chronic L5 radiculopathy, peroneal nerve palsy, right foot drop, and fibrosis.

6. Claimant was placed in an aggressive and lengthy rehabilitation program because of these serious complications. Claimant received extensive physical therapy, medication therapy, and was required to use a TENS unit for the pain.

7. The last time Dr. Bruce saw claimant was on February 7, 1995. In a letter to respondent's insurance carrier dated May 8, 1995, Dr. Bruce assessed claimant with a 42 percent whole body functional impairment. He restricted claimant from lifting over 20 pounds along with no repetitive bending, stooping, or lifting. He further indicated that claimant may require restrictions on sitting of no longer than two hours at a time.

8. Claimant returned to work for the respondent and eventually terminated his employment with respondent to go into the restaurant business on his own. Claimant testified that, after he returned to work, he still remained symptomatic and had flare-ups of increased pain in his low back and legs approximately every six months. After the flare-ups, claimant had to either seek medical treatment, or on his own, he took pain medication, provided himself with ice and heat therapy, plus bed rest.

9. On July 8, 1996, claimant stood up to exit his car, and he suddenly felt numbness and weakness in both legs. Claimant was taken to St. Luke's Hospital emergency room in Kansas City, Missouri, and then was seen by C. Keith Whittacker, M.D., on July 10, 1996. A July 9, 1996, MRI examination was interpreted by Dr. Whittacker to indicate an abnormality at L4-L5 on the right. The doctor believed the abnormality was scar tissue from the 1993 surgeries and a subsequent infection. Claimant was treated with pain and anti-inflammatory medications.

10. Claimant had another episode with his back on October 10, 1996, when he bent over to kiss his son and coughed. He had severe pain down his left leg and in both hips.

He again went to Dr. Whittacker on October 14, 1996, who diagnosed claimant with adhesive arachnoiditis (inflammation causing nerve root irritation). Dr. Whittacker believed claimant "twanged" one or several nerve roots when he coughed. Again claimant was treated with pain and anti-inflammatory medication.

11. Respondent's insurance carrier refused to pay the medical expenses for claimant's treatment for both the July 8, 1996, and October 10, 1996, episodes. Respondent took the position that claimant had been released and assessed with a final permanent partial impairment by Dr. Bruce on May 8, 1995. Thus, respondent contended the two episodes in question occurred after claimant had met maximum medical improvement from his September 12, 1993, accident and there was no proof the medical expenses were related to that accident.

Following a June 12, 1997, preliminary hearing, the Administrative Law Judge found otherwise and ordered respondent's insurance carrier to pay the medical expenses. The Administrative Law Judge found claimant had suffered substantial complications during the medical treatment for his September 12, 1993, low-back injury. As a result of these complications, claimant's low-back condition was of such a serious nature that it required continued medical treatment.

12. In February of 1999, claimant sneezed and had another sudden exacerbation of low-back pain. At this time, claimant again contacted respondent's insurance carrier and requested medical treatment for the low-back pain. The insurance carrier denied claimant's request.

13. Claimant went on his own to his family physician, Charles M. Singleton, M.D. The doctor had claimant undergo an MRI examination on February 5, 1999. The MRI showed a moderate progression of the size of the focal disk protrusion and an extruding disk fragment at the L4-5 level. Further, the MRI examination showed a small, focal, central disk protrusion and small extruded disk fragment at L5-L6 and mild epidural fibrosis in the right lateral recess at L5-L6.¹ Claimant was placed on medication and bed rest by Dr. Singleton. The doctor then referred claimant to neurosurgeon Paul J. Camarata, M.D.

Dr. Camarata first saw claimant on March 3, 1999. Dr. Camarata was a physician in the same medical group as claimant's previous treating physician, Dr. Whittacker, who had retired. Claimant related to the doctor a history of a sudden exacerbation of pain in

¹This MRI examination indicates claimant has six lumbar vertebrae. Thus, when the 1993 MRI reports describe the L5-S1 vertebra level this is the same level as described in 1999 MRI reports as the L5-L6 vertebra level.

his low back extending mostly into the left leg. As a result, claimant had been essentially bed ridden for a number of days. At this time, however, Dr. Camarata found claimant improved with no leg pain and mild back pain. The majority of the deficits found from Dr. Camarata's neurological examination, the partial right foot drop, and sensory loss were attributed to claimant's previous 1993 disk surgery and subsequent diskitis.

14. In August of 1999, claimant experienced another exacerbation of low-back and leg pain. He returned to Dr. Camarata seeking relief from the increased pain and discomfort.

Dr. Camarata diagnosed claimant with a lumbar disk herniation at L4-L5. Because of claimant's continuing painful condition, Dr. Camarata decided claimant required emergency surgery. On September 2, 1999, the doctor performed a discectomy and decompression at the L4-L5 level on the left. The doctor's operative note indicates he "came upon a buried disk fragment directly underneath the L5 nerve root." This large free fragment was removed along with the remaining degenerative nucleus pulposus. This decompressed the nerve root and thecal sac.

15. After the surgery, claimant testified he had never felt better since the September 12, 1993, accident. In fact, claimant testified the most immediate change in his condition was that his right foot drop greatly improved. Claimant was now able to lift his right foot which he had not been able to do since the 1993 surgeries.

CONCLUSIONS OF LAW

1. The claimant has the burden to prove by a preponderance of the credible evidence his right to an award of compensation by proving the various conditions on which that right depends.²

2. Here, the respondent argues claimant has failed to meet his burden because he failed to present expert medical testimony that his September 2, 1999, surgery was reasonably related his September 12, 1993, work-related low-back injury.

3. In a worker compensation case, the fact-finder's function is to decide which testimony is more accurate and credible and to adjust the medical testimony along with testimony of the claimant and any other relevant testimony to decide the nature and

²See K.S.A. 1999 Supp. 44-510(a) and K.S.A. 1999 Supp. 44-508(g).

extent of claimant's disability.³ Furthermore, medical testimony is not necessary to the establishment of the existence or nature and extent of an injured worker's disability.⁴

4. The Appeals Board finds claimant established through his testimony that after the two 1993 back surgeries he suffered severe medical complications that left him with a serious continuing permanent low-back condition. On several occasions, claimant experienced exacerbations of his continuing low-back and leg pain that required him to seek medical treatment. These exacerbations were not associated with any intervening significant traumatic event but occurred out of the ordinary pattern of life.

Finally, in August of 1999, the last exacerbation incident necessitated surgical intervention where the surgeon found and removed a large free disk fragment from the nerve root at the L4-L5 level. The L4-L5 vertebra level is the same level that the surgeon performed a discectomy during claimant's second surgery on October 20, 1993. After the 1993 surgeries, claimant developed a right foot drop. This condition immediately improved after the large disk fragment was removed during the September 2, 1999, surgery.

5. The Appeals Board concludes the record as a whole has proven that the medical treatment claimant needed in 1999, including the September 2, 1999, surgical procedure, was a natural and probable consequence of his original September 12, 1993, work-related low-back injury.⁵ The Workers Compensation Act places the duty on respondent to provide medical treatment that may be reasonably necessary to cure and relieve the employee from the effects of the injury.⁶ In this case, claimant requested medical treatment for a low-back condition that was directly related to his September 12, 1993, work-related injury, and respondent denied the request. Thus, the Appeals Board finds, because of this refusal, claimant was required to provide the necessary medical treatment and the respondent is, therefore, liable for the medical expenses.

6. Respondent also contends the Administrative Law Judge erred in referring the medical bills to the Division Medical Director for review.⁷

³See Tovar v. IBP, Inc., 15 Kan. App. 2d 782, 817 P.2d 212, *rev. denied* 249 Kan. 778 (1991).

⁴See Chinn v. Gay & Taylor, Inc., 219 Kan. 196, Syl. ¶ 3, 547 P.2d 751 (1976).

⁵See Gillig v. Cities Service Gas Co., 222 Kan. 369, 372, 564 P.2d 548 (1977).

⁶See K.S.A. 1999 Supp. 44-510(b).

⁷See K.S.A. 1999 Supp. 44-510.

The Appeals Board cannot find in the record a dispute raised by either party on the question of whether the medical bills were in compliance with the medical fee schedule. Since neither party requested the review and there was no dispute over the amount of the medical bills, the Appeals Board is at a loss for a reason the Administrative Law Judge found a review necessary. The Administrative Law Judge does, however, have authority to make such a review request. The Appeals Board finds no reason to disturb this order and therefore affirms the Administrative Law Judge's decision to request the review.

AWARD

WHEREFORE, it is the finding, decision, and order of the Appeals Board that Administrative Law Judge Robert H. Foerschler's November 9, 1999, Preliminary Decision that ordered the respondent to pay medical expenses incurred by claimant for medical treatment necessary to cure or relieve the effects of his September 12, 1993, low-back injury, should be, and is hereby, affirmed in all respects.

IT IS SO ORDERED.

Dated this ____ day of February 2000.

BOARD MEMBER

BOARD MEMBER

BOARD MEMBER

c: John G. Eisele, Kansas City, MO
Kristine A. Purvis, Overland Park, KS
Robert H. Foerschler, Administrative Law Judge
Philip S. Harness, Director